(2) To a nonparticipating hospital on the individual's behalf for emergency outpatient services furnished by the hospital, in accordance with subpart G of part 424 of this chapter.

(3) To the individual, for emergency outpatient services furnished by a nonparticipating hospital, in accordance with § 424.53 of this chapter.

(4) To the individual, for physicians' services and ambulance services furnished outside the United States in accordance with § 424.53 of this chapter.

(5) To a provider on the individual's behalf for medical and other health services furnished by the provider (or by others under arrangements made with them by the provider).

(6) To a home health agency on the individual's behalf for home health services furnished by the home health agency.

(7) To a clinic, rehabilitation agency, or public health agency on the individual's behalf for outpatient physical therapy or speech pathology services furnished by the clinic or agency (or by others under arrangements made with them by the clinic or agency).

(8) To a rural health clinic or Federally qualified health center on the individual's behalf for rural health clinic or Federally qualified health center services furnished by the rural health clinic or Federally qualified health center, respectively.

(9) To an ambulatory surgical center (ASC) on the individual's behalf for covered ambulatory surgical center facility services that are furnished in connection with surgical procedures performed in an ASC, as provided in part 416 of this chapter.

(10) To a comprehensive outpatient rehabilitation facility (CORF) on the individual's behalf for comprehensive outpatient rehabilitation facility services furnished by the CORF.

(11) To a renal dialysis facility, on the individual's behalf, for institutional or home dialysis services, supplies, and equipment furnished by the facility.

(12) To a rural primary care hospital (RPCH) on the individual's behalf for outpatient RPCH services furnished by the RPCH.

(13) To a community mental health center (CMHC) on the individual's behalf, for partial hospitalization services furnished by the CMHC (or by others under arrangements made with them by the CMHC).

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 24981, June 12, 1992; 58 FR 30668, May 26, 1993; 59 FR 6577, Feb. 11, 1994]

§ 410.152 Amounts of payment.

(a) *General provisions*—(1) *Exclusion from incurred expenses.* As used in this section, ''incurred expenses'' are expenses incurred by an individual, during his or her coverage period, for covered Part B services, excluding the following:

(i) Expenses incurred for services for which the beneficiary is entitled to have payment made under Medicare Part A or would be so entitled except for the application of the Part A deductible and coinsurance requirements.

(ii) Expenses incurred in meeting the Part B blood deductible (§ 410.161).

(iii) In the case of services payable under a formula that takes into account reasonable charges, reasonable costs, customary charges, customary (insofar as reasonable) charges, charges related to reasonable costs, fair compensation, a pre-treatment prospective payment rate, or a standard overhead amount, or any combination of two or more of these factors, expenses in excess of any factor taken into account under that formula.

(iv) In the case of physician and CORF services for the treatment of a mental, psychoneurotic, or personality disorder, furnished to an individual who is not an inpatient of a hospital, the expenses excluded from incurred expenses under § 410.155(c).

(v) In the case of expenses incurred for outpatient physical therapy furnished by therapists in independent practice, expenses in excess of $500 in reasonable charges incurred in a calendar year.

(2) *Other applicable provisions.* Medicare Part B pays for incurred expenses the amounts specified in paragraphs (b) through (k) of this section, subject to the following:

(i) The principles and procedures for determining reasonable costs and reasonable charges and the conditions for Medicare payment, as set forth in parts

405 (subparts E and X), 413, and 424 of this chapter.

(ii) The Part B annual deductible (§ 410.160).

(iii) The special rules for payment to health maintenance organizations (HMOs), health care prepayment plans (HCPPs), and competitive medical plans (CMPs) that are set forth in part 417 of this chapter. (A prepayment organization that does not qualify as an HMO, CMP, or HCPP is paid in accordance with paragraph (b)(4) of this section.)

(b) *Basic rules for payment.* Except as specified in paragraphs (c) through (h) of this section, Medicare Part B pays the following amounts:

(1) For services furnished by, or under arrangements made by, a provider other than a nominal charge provider, whichever of the following is less:

(i) 80 percent of the reasonable cost of the services.

(ii) The reasonable cost of, or the customary charges for, the services, whichever is less, minus 20 percent of the customary (insofar as reasonable) charges for the services.

(2) For services furnished by, or under arrangements made by, a nominal charge provider, 80 percent of fair compensation.

(3) For emergency outpatient hospital services furnished by a nonparticipating hospital that is eligible to receive payment for those services under subpart G of part 424 of this chapter, the amount specified in paragraph (b)(1) of this section.

(4) For services furnished by a person or an entity other than those specified in paragraphs (b)(1) through (b)(3) of this section, 80 percent of the reasonable charges or 80 percent of the payment amount computed on any other payment basis for the services.

(c) *Amount of payment: Home health services other than durable medical equipment (DME).* For home health services other than DME furnished by, or under arrangements made by, a participating HHA, Medicare Part B pays the following amounts:

(1) For services furnished by an HHA that is a nominal charge provider, 100 percent of fair compensation.

(2) For services furnished by an HHA that is not a nominal charge provider, the lesser of the reasonable cost of the services and the customary charges for the services.

(d) *Amount of payment: DME furnished as a home health service.*

(1) *Basic rule.* Except as specified in paragraph (d)(2) of this section—

(i) For DME furnished by an HHA that is a nominal charge provider, Medicare Part B pays 80 percent of fair compensation.

(ii) For DME furnished by an HHA that is not a nominal charge provider, Medicare Part B pays the lesser of the following:

(A) 80 percent of the reasonable cost of the service.

(B) The reasonable cost of, or the customary charge for, the service, whichever is less, minus 20 percent of the customary (insofar as reasonable) charge for the service.

(2) *Exception.* If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for new equipment—

(i) For used DME furnished by an HHA that is a nominal charge provider, Medicare Part B pays 100 percent of fair compensation.

(ii) For used DME furnished by an HHA that is not a nominal charge provider, Medicare Part B pays 100 percent of the reasonable cost of, or the customary charge for, the services, whichever is less.

(e) *Amount of payment: Renal dialysis services, supplies, and equipment.* Effective for services furnished on or after August 1, 1983, Medicare Part B pays for the institutional dialysis services specified in § 409.250 and the home dialysis services, supplies, and equipment specified in § 409.252, as follows:

(1) Except as provided in paragraph (d)(2) of this section, 80 percent of the per treatment prospective reimbursement rate established under § 413.170 of this chapter, for outpatient maintenance dialysis furnished by ESRD facilities approved in accordance with subpart U of part 405 of this chapter.

(2) *Exception.* If a home dialysis patient elects to obtain home dialysis supplies or equipment (or both) from a

party other than an approved ESRD facility, payment is in accordance with paragraph (b)(4) of this section.

(f) *Amount of payment: Rural health clinic and Federally qualified health center services.* Medicare Part B pays, for services by a participating independent rural health clinic or Federally qualified health center, 80 percent of the costs determined under subpart X of part 405 of this chapter, to the extent those costs are reasonable and related to the cost of furnishing rural health clinic or Federally qualified health center services or reasonable on the basis of other tests specified by HCFA.

(g) *Amount of payment: Used durable medical equipment furnished by otherthan an HHA.* Medicare Part B pays the following amounts for used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment:

(1) For used DME furnished by, or under arrangements made by, a nominal charge provider, 100 percent of fair compensation.

(2) For used DME furnished by or under arrangements made by a provider that is not a nominal charge provider, 100 percent of the reasonable cost of the service or the customary charge for the service, whichever is less.

(3) For used DME furnished by other than a provider, 100 percent of the reasonable charge.

(h) *Amount of payment: Pneumococcal vaccine.* Medicare Part B pays for pneumococcal vaccine and its administration as follows:

(1) For services furnished by a nominal charge provider, 100 percent of fair compensation.

(2) For services furnished by a provider that is not a nominal charge provider, the reasonable cost of the services or the customary charge for the service, whichever is less.

(3) For services furnished by other than a provider, a rural health clinic or a Federally qualified health center, 100 percent of the reasonable charge.

(4) For services furnished by a rural health clinic or a Federally qualified health center, 100 percent of the reasonable cost.

(i) *Amount of payment: ASC facility services.* For ASC facility services that are furnished in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays 80 percent of a standard overhead amount, as specified in §416.120(c) of this chapter.[1]

(j) *Amount of payment: services of Federally funded health facilities prior to October 1, 1991.* Medicare Part B pays 80 percent of charges related to the reasonable costs that a Federally funded health facility incurs in furnishing the services. See §411.8(b)(6) of this chapter.

(k) *Amount of payment: Outpatient RPCH services.* (1) *General.* For services furnished by an RPCH to its outpatients, Medicare Part B payment is made under either one of the following methods elected by the RPCH.

(2) *Cost-based RPCH facility services payment plus professional medical services payment method.* Payment for RPCH facility services is made in accordance with §413.70(b)(2)(i) of this chapter, and payment for professional medical services is made on a reasonable charge or other fee basis in accordance with §413.70(b)(2)(ii) of this chapter and with the other provisions of this chapter that apply to payment for professional medical services when they are not included in outpatient RPCH services.

(3) *All-inclusive rate method.* Payment for both RPCH facility services and professional medical services is made at a single all-inclusive rate per visit, subject to the applicable Part B deductible and coinsurance amounts, as described in §413.70(b)(3) of this chapter.

[51 FR 41339, Nov. 14, 1986; 52 FR 4499, Feb. 12, 1987, as amended at 53 FR 6648, Mar. 2, 1988; 56 FR 2138, Jan. 22, 1991; 56 FR 8841, Mar. 1, 1991; 57 FR 24981, June 12, 1992; 58 FR 30668, May 26, 1993; 59 FR 63462, Dec. 8, 1994]

[1] For services furnished before July 1, 1987, Medicare Part B paid 100 percent of the standard amount.

§ 410.155 Outpatient mental health treatment limitation.

(a) *Definitions.* As used in this section, unless the context indicates otherwise, ''*Mental, psychoneurotic, or personality disorder*'' means the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual—Mental Disorders. ''*Hospital*'' means any hospital that is primarily engaged in providing, by or under the supervision of physicians, diagnostic and therapeutic services for the medical diagnosis, treatment, and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons; or psychiatric services for the diagnosis and treatment of mentally ill persons; and medical services for the diagnosis and treatment of tuberculosis.

(b) *Services subject to limitation.* The mental health treatment limitation applies to the following services furnished for the treatment of a mental, psychoneurotic, or personality disorder, when the services are furnished to an individual who is not an inpatient in a hospital:

(1) CORF services.

(2) Physicians' services that meet the criteria of part 405, subpart F of this chapter for payment on a fee schedule basis in accordance with part 414 of this chapter.

(3) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act, that are furnished after December 31, 1990.

(4) Clinical psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990.

(c) *Limitation on incurred expenses*—(1) *Current limit.* For purposes of §§ 410.152 and 410.160, incurred expenses for the services specified in paragraph (b) of this section exclude expenses that are in excess of 62½ percent of the sum of the reasonable charges for physician services and the customary charges for CORF services.

(2) *Previous limits.* For years before calendar year 1990, incurred expenses that could be considered were limited to the lower of the current 62½ percent and a fixed dollar amount that—

(i) For calendar years before 1988, was $312.50;

(ii) For calendar year 1988, was $562.50; and

(iii) For calendar year 1989, was $1,375.

(d) *Example.*

As a private patient, Mr. X's only medical expenses during the calendar year 1982 amounted to $750 for physicians' services in connection with the treatment of a mental disorder which did not require inpatient hospitalization. The statutory limit for any calendar year on the amount of these expenses that is covered under this subpart B is $312.50 ($312.50 being lesser in amount than 62½ percent of $750). Mr. X is required to meet the first $75 as a deductible, and 20 percent of the balance. The remaining 80 percent is payable under this subpart B.

Total covered expenses	Mr. X's payment	Payment under subpart B
$312.50	[2] $437.50	
−75.00 [1]	[1] 75.00	
237.50	[3] 47.50	[4] 190.00

[1] Deductible, as described in § 409.360.
[2] In excess of $312.50.
[3] 20 percent of total covered expenses less deductible.
[4] 80 percent of total covered expenses less deductible.

If Mr. X had incurred $350 of the above expenses while an inpatient of an institution (see paragraph (b) of this section), and the remaining $400 while not an inpatient of an institution, payment would be computed as follows:

Total covered expenses	Mr. X's payment	Payment under subpart B
$250 [1]	[2] $150	
+350 [3]		
600	[4] 75	
−75		
525	[5] 105	[6] 420

[1] 62½ percent of $400.
[2] In excess of 62½ percent of $400.
[3] 100 percent of expenses incurred while an inpatient.
[4] Deductible.
[5] 20 percent of total covered expenses less deductible.
[6] 80 percent of total covered expenses less deductible.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8842, Mar. 1, 1991; 58 FR 30668, May 26, 1993; 59 FR 6578, Feb. 11, 1994]

§ 410.160 Part B annual deductible.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, incurred expenses (as defined in § 410.152) are subject to, and count toward meeting the annual deductible.

(b) *Exceptions.* Expenses incurred for the following services are not subject